Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Cairn Hill Nursing Home
Centre ID:	0019
Centre address:	Westminister Road Foxrock, Dublin 18
Telephone number:	01 2896885
Fax number:	01 2891003
Email address:	info@cairnhillnursinghome.com
Type of centre:	☒ Private ☐ Voluntary ☐ Public
Registered providers:	BRD Nursing Home Ltd
Person in charge:	Anna Patterson
Date of inspection:	3 August 2011
Time inspection took place:	**Start:** 07:45 hrs **Completion:** 16:15 hrs
Lead inspector:	Fiona Whyte
Support inspector:	Mary O Donnell
Type of inspection:	☒ Announced ☐ Unannounced
Purpose of this inspection visit	☐ Application to vary registration conditions ☐ Notification of a significant incident or event ☐ Notification of a change in circumstance ☐ Information received in relation to a complaint or concern ☒ Regulatory Monitoring Visit

About the inspection

The purpose of inspection is to gather evidence on which to make judgments about the fitness of the registered provider and to report on the quality of the service. This is to ensure that providers are complying with the requirements and conditions of their registration and meet the Standards, that they have systems in place to both safeguard the welfare of service users and to provide information and evidence of good and poor practice.

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Inspections take place under the following circumstances:

- to follow up on specific matters arising from a previous inspection to ensure that the action required of the provider has been taken
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Social Services Inspectorate that a provider has appointed a new person in charge
- arising from a number of events including information received in relation to a concern/complaint or notification to the SSI of a significant event affecting the safety or well-being of residents
- to carry out a regulatory monitoring visit focussing on key regulatory requirements.

All inspections can be announced or unannounced, depending on the reason for the inspection and may take place at any time of day or night.

All inspection reports produced by the Health Information and Quality Authority will be published. However, in cases where legal or enforcement activity may arise from the findings of an inspection, the publication of a report will be delayed until that activity is resolved. The reason for this is that the publication of a report may prejudice any proceedings by putting evidence into the public domain.

About the centre

Description of services and premises

Cairn Hill is an original Georgian period building with a purpose built extension. It has 42 places and provides short term and long term care predominantly for older people. A significant number of residents have dementia care needs.

The centre is a two storey building with five levels. There are a number of stairs and a lift to all levels. There are electronic gates leading to the centre and there is an entrance to the front of the building accessed by steps which is not in use. There is a second entrance at ground level which is used on a daily basis and is wheelchair accessible.

Residents' bedroom accommodation is located over four levels. There are 31 single rooms, four twin rooms and one three-bedded room. Eight bedrooms have en suite toilet and wash-hand basin facilities while all the remaining bedrooms have en suite shower, toilet and wash-hand basins.

On Level 1 there are nine single bedrooms and one twin room. There is also a laundry, a sluice, storage facilities and an assisted bathroom on this level.

On Level 2 there are two large sitting rooms to the front of the centre. There is a spacious dining room with the kitchen adjacent. There is a conservatory off the dining room overlooking the landscaped rear garden. There is also a nurses' office, person in charges' office, staff room and three assisted toilets.

On Level 3 there are nine single and two twin rooms, all bedrooms have en suite shower facilities. The linen storage, a sluice room as well as a treatment room and a hair salon are also on this level.

On Level 4 there are eight single bedrooms, one twin room and one three-bedded room. There is also one large shower/wet room and a small nurses' station.

On Level 5 there are five single bedrooms and an assisted bathroom.

The garden is mature with walkways and a gazebo for residents to sit. There is limited parking immediately to the front of the centre but additional parking is available on the road outside. There is a CCTV system in operation on the grounds and in the communal areas of the centre.

Location

The centre is located just off the Stillorgan dual carriageway on the N11, approximately 6 miles from Dublin's city centre. It is located in a residential housing estate and is close to a bus route with direct access to Dublin city centre.

Date centre was first established:	1999
Number of residents on the date of inspection	41

Dependency level of current residents	**Max**	**High**	**Medium**	**Low**
Number of residents	16	5	7	13

Management structure

Cairn Hill is a family business owned by BRD Nursing Home Ltd. The nominated persons on behalf of the Provider are Brian and Rita McMahon. The Person in Charge is Anna Patterson and she reports to the Provider. There is a Clinical Nurse Manager Level 1 (CNM1) as well as a team of nurses who report to the Person in Charge. There is also a Physiotherapist and an Activities Coordinator who report to the Person in Charge. Care assistants report to the senior care assistants who in turn report to the nurses. There is a Support Services Manager to whom the catering, cleaning and maintenance personnel report to and who reports directly to the Provider.

Number of staff on duty on day of inspection:	**Person in Charge**	**Nurses**	**Care staff**	**Catering staff**	**Cleaning and laundry staff**	**Admin staff**	**Other staff**
Morning	1	1 + CNM1	9	3	2 cleaning	0	* 5
Afternoon	1	1 + CNM1	6	2	1 laundry		
Evening	1	1	5	0	0		
Night	0	1	2	0	0		

* The provider, physiotherapist, activities coordinator, support services manager and maintenance man.

Summary of findings from this inspection

This report sets out the findings of a monitoring and compliance inspection, which took place on 3 August 2011. The inspection was carried out to examine how well the provider is meeting the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland.*

Inspectors met with residents, relatives, and staff members during the inspection. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

The provider and person in charge had systems in place to support strong clinical governance and they demonstrated their knowledge of their legal responsibilities. In advance of this inspection the person in charge with the provider had reviewed and updated the fit person self-assessment document and submitted it to the Authority. Inspectors were able to confirm during the inspection the many improvements which were highlighted in the self-assessment document and implemented since the registration inspection in January 2010. For example, an activities coordinator had been employed on a part-time basis and a bi-annual staff performance and appraisal process implemented.

Inspectors also reviewed the actions from the previous inspection of 28 April 2011 and confirmed that 10 actions were completed, 2 actions were partially completed and 1 action still required to be completed.

While some areas for improvement were identified, overall inspectors found that the provider and person in charge met the requirements of the Regulations and had established strong management and leadership processes.

There was evidence of very good practice in all areas. The provider, person in charge and staff demonstrated a comprehensive knowledge of residents' needs, their likes, dislikes and preferences. Staff and residents knew each other well, referring to each other by first names. Residents were observed to be relaxed and comfortable when conversing with staff.

The health care needs of residents were met to a very high standard. Residents had access to medical cover and to a range of other health services and evidence-based nursing care was provided.

Some improvements were required in risk management, assessing staffing levels and provision of choice to residents. These areas for improvement are discussed further in the report and are included in the Action Plan at the end of the report.

Governance

Regulation 15: Person in Charge

The person in charge was a registered nurse and worked full-time. She was on duty five days a week, normally Monday to Friday. She had been employed in the post since May 2010 and prior to that was employed as Director of Nursing in a large residential centre for older people. She had completed and attended many courses and held a Bachelor of Arts degree in Health Studies.

The CNM1 deputised in the absence of the person in charge. She was qualified and competent to deputise in her absence and demonstrated this both through her clinical knowledge of the residents on the day of inspection.

The person in charge had very good knowledge of the Regulations and Standards and her statutory responsibilities were sufficiently demonstrated throughout the inspection and by the documentation reviewed. Throughout the inspection process, the person in charge demonstrated competence, insight and a commitment to delivering good quality care to residents. Inspectors observed that she had a strong and inclusive presence in the centre and there was evidence of strong leadership. All documentation requested by the inspector was readily available.

Residents and staff spoken to said that the person in charge was very approachable and were satisfied that should they have a concern or issue that it would be dealt with in an efficient, appropriate and timely manner.

Regulation 16: Staffing

Inspectors were concerned that staffing levels at night might not be adequate to meet the needs and ensure the safety of the residents. Inspectors identified the need to review these staffing levels to ensure residents' healthcare and safety needs were met. While residents' dependency levels were assessed using a validated tool and there were usually two nurses and nine care assistants on duty during the day time. However, this reduced considerably to one nurse and two care assistants on duty at night time. This reduction in staffing levels as well as the number of residents and the design and layout of the building presented some difficulties for staff on night duty. While the nurse administered medications on night duty she was unable to supervise the delivery of care. Inspectors were also concerned that the current staffing levels at night presented a risk to residents in the event of an emergency or if the building required to be evacuated during the night.

There was a comprehensive written operational recruitment policy. Inspectors examined a number of staff files and noted they contained most of the information required by the Regulations including Garda Síochána vetting and the registration numbers of all nurses. However, while there was a self declaration of medical fitness

maintained on staff files, there was no evidence to support this and was not in accordance with the requirements of the Regulations.

Staff turnover was low and most of the staff had worked in the centre for a number of years. They were knowledgeable about residents, had established a good relationship with them and the inspector saw them responding to residents' needs in an informed way. Staff were clear about their roles and responsibilities and were able to explain these to the inspector.

Staff spoken to confirmed that they were supported, encouraged and had opportunities to attend training courses appropriate to their roles. The provider and person in charge were committed to providing ongoing training to staff. Inspectors read the training records which indicated that extensive training had been undertaken including training on caring for residents with dementia and subcutaneous fluids. Nursing staff had undertaken the e-learning medication management programme. Additional training planned for 2011 included managing behaviour that challenged, caring for residents with dementia, whistle blowing and medication management. Staff spoken with confirmed that they had attended training and their certificates of attendance were maintained on their files. A formal staff appraisal system was implemented recently and was being used to identify staff training needs.

All except three care assistants had completed the eight module Further Education and Training Awards Council (FETAC) Level 5 training. Staff spoken with confirmed how much they had enjoyed doing the training and how it helped them in their work.

Regulation 31: Risk Management Procedures

Inspectors had concerns that some practices in relation to the management of risk did not sufficiently promote the safety of residents, staff and visitors.

Inspectors noted that all levels within the centre were accessible by stairs and they varied in height. Many residents were cognitively impaired and would not readily understand the dangers these open stairwells posed. There were no risk assessments undertaken to ensure control measures were in place to minimise the risk of residents falling down the stairs. The provider gave an assurance that this issue would be dealt with immediately.

In addition inspectors noted that all the stairs in the centre had a handrail on one side only and this posed a further safety risk to residents.

There was a health and safety statement in place and a comprehensive risk management policy developed with the input of management and staff, and approved on 28 February 2011. The risk register included environmental and clinical risk assessments and outlined the potential hazard, current control, impact rating, likelihood rating, resulting risk level and additional controls required. The risk management policy also provided guidelines on risks such as assault, accidental injury or self harm.

There was an emergency plan in place but it required some development. It contained information on the management of emergencies such as fire and identified alternative accommodation in the event of residents having to be evacuated. However, it did not provide guidance on what to do in the event of other emergencies such as power failure, loss of heating and disruption to water supply.

Staff were generally knowledgeable on procedures to prevent cross infection. However, the laundry staff stated that sluicing of soiled laundry was regularly undertaken in the sluice room and then transported along the corridor in a basin to the laundry. This practice posed a risk of infection. Staff had access to supplies of latex gloves and disposable aprons and they were observed using the alcohol hand gels which were available throughout the centre. There were arrangements in place for the segregation and disposal of waste, including clinical waste.

Cleaning detergents and chemicals were noted to be stored unsecured in the kitchen where food was being prepared despite the kitchen having access to a separate cleaning store for cleaning equipment.

The person in charge had a robust system in place to audit accidents and incidents. Records were maintained accurately and outcomes and additional measures were put in place to increase the safety of residents. Comprehensive auditing of incidents and accidents had commenced in 2011 to identify trends for the purpose of improving the quality of service and safety of all residents. Minutes of staff meetings showed where these audits were discussed at all meetings. Records showed that a resident had absconded from the centre recently. The incident was managed appropriately, learning from the incident was recorded and specific measures were put in place to prevent a recurrence. The person in charge was gathering additional clinical data such as use of catheters, falls and incidence of organic illness. She was using the data to identify possible trends and for the purpose of improving the quality of service and safety of residents.

Inspectors reviewed the training records and noted that all staff had received training on moving and handling. Staff spoken with were knowledgeable on the correct moving and handling techniques. Inspectors also observed staff using the equipment such as hoists appropriately.

Regulation 39: Complaints Procedures

Inspectors were satisfied that complaints were well managed but the policy and procedure required some improvements.

The complaints policy did not identify to whom a person could make a complaint to and it did not contain details of an independent appeals process. The complaints procedure was on display in several prominent areas of the building. However, the procedure on display was a flow chart and was very difficult to read. It also did not state clearly who a person could complain to and the independent appeals process.

The complaints log was reviewed and inspectors noted there were three complaints received in 2011. All complaints were recorded accurately, they detailed the outcome and whether the resident was satisfied or not. The inspector noted correspondence from relatives and residents complimenting the service were also maintained. The person in charge had compiled a resume of all complaints so that they could be viewed and audited at a glance for the purpose of identifying trends and ensuring closure.

Residents told the inspector they knew who to complain to or raise any query with should the need arise.

Regulation 36: Notification of Incidents

Inspectors noted that residents with pressure ulcers grade two or higher were not notified to the Chief Inspector as required. The person in charge stated she would submit the notifications immediately.

Practice in relation to all other notifications was satisfactory. The person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. To date all relevant incidents had been notified to the Chief Inspector by the person in charge.

Resident Care

Regulation 9: Health Care

Inspectors were satisfied that residents' general healthcare needs were met to a high standard.

All residents had access to general practitioner (GP) services and residents could choose to retain their own GP if they so wished. There was an out-of-hours GP service available. The medication charts confirmed that all medications were prescribed in accordance with best practice and reviewed on a three-monthly basis by the GP.

The person in charge told inspectors that residents had access to a wide range of health professionals and records of appointments and referrals were maintained in residents' files. A full-time physiotherapist was employed and all residents had access to her on a daily basis. During the inspection it was noted that she encouraged and supported residents to mobilise both independently and with support. Residents' care plans were updated to reflect any interventions she recommended. Residents had access to speech and language therapy, occupational therapy (OT) and dietetic services on referral and recommendations were noted to be incorporated into residents care plans. Chiropody, dental and optical services were available in house on referral.

The clinical nurse specialist (CNS) in mental health visited the centre to review residents on referral and there were strong links with the Blackrock hospice care team. Inspectors noted their records maintained on residents files.

Inspectors reviewed a sample of residents' files including the files of residents with wounds and challenging behaviour. Records were clearly maintained and information was very easy to access. Information was very person-centred and individualised to each resident. A comprehensive nursing assessment was completed for all residents. Up-to-date individual risk assessments were carried out for prevention of falls, risk of developing pressure ulcers, pain, manual handling, continence and nutrition. 'A Key to Me' was completed for each resident which outlined key events and dates for the resident. An activity assessment was completed for each resident including attendance and evaluation of activities. Residents had care plans in place for all identified needs and they were updated three monthly or sooner according to the residents changing needs. Inspectors noted that the resident and/or representative was involved in the review.

Residents with pressure ulcers and those at risk of malnutrition had assessments undertaken and care plans in place. Additional specialist equipment was provided as indicated by the assessment and referral to specialist services. Turning and mobilising charts were also maintained.

Inspectors reviewed the policy on behaviour that challenged and the use of restraint and found them to be comprehensive, well researched and gave clear guidance to staff. The policies informed practice as inspectors saw that assessment tools were being used with residents who displayed behaviour that challenged on a regular basis. The tool assessed triggers and episodes of aggressive behaviour were recorded. Inspectors noted that bedrails and lap belts were in use for some residents. Assessments were completed for the use of restraint and there was evidence of consultation and alternative measures that had been considered.

Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines

Inspectors found evidence of good medication management procedures and practices in place.

The inspector reviewed the medication policy which was found to be comprehensive and gave clear guidance to nursing staff on all areas of medication management including the prescribing, administration, storage and disposal of medications.

One inspector accompanied the nurse on a medication round. The nurse demonstrated her competence and knowledge when outlining procedures and practices in medication management. Medications which required strict controls were managed in accordance with the legislation.

There were no residents self-administering their medications but there were appropriate policies and procedures in place to ensure safe administering of medications could be undertaken by residents if appropriate.

Medication management was audited by the pharmacist. Audits were carried out three monthly and the last audit was in June 2011. Inspectors noted there were three medication errors, all were managed appropriately and documented accurately including the measures put in place to prevent recurrence.

Regulation 6: General Welfare and Protection

Inspectors found that measures were in place to protect residents from being harmed or abused. Improvement was required to ensure the more dependent and cognitively impaired residents received meaningful interaction and stimulation.

Inspectors reviewed the policy on the protection of residents from abuse and the policy on responding to allegations of abuse. Both were comprehensive and staff were able to identify the various types of abuse and what they would do if an allegation was made to them. All staff spoken to and training records reviewed confirmed that all staff had either received training or were scheduled to receive training on identifying and responding to elder abuse. There had been no allegations of abuse. There was also a whistle blowing policy in place to ensure there were no barriers to the disclosure of abuse. There was a process in place where policies were prioritised and discussed with staff. This was a formal process whereby time was set aside daily for all staff to come together to discuss the policies. Residents spoken to

and those who completed questionnaires confirmed to inspectors that they felt safe in the centre. They primarily attributed this to the staff who cared for them.

There was an activities coordinator employed on a part-time basis. She worked hard to meet residents' needs for social engagement and occupation in a meaningful way. Each resident had their social needs assessed and their interests and hobbies incorporated into the activity schedule. Three residents who did not attend the activities in the day rooms and who shared a bedroom on an upper level had individual daily activities programmes developed. They were visited daily by either the activities coordinator or a carer in her absence, for one to one activities. All residents had individual activity plans developed by the activities coordinator, in consultation with the person in charge, and the plans were implemented by staff. Multi-sensory equipment had been purchased to provide sensory stimulation for them. On the day of inspection it was noted that the musician who came in to play music for the residents also went to these residents' bedroom to play for them. However, it was noted that activities were limited for those residents who were more dependent and cognitively impaired than for residents' who were more independent and able to participate. The person in charge said that she would seek additional training for the activity coordinator in the provision of suitable activities for residents with these needs.

Regulation 10: Residents' Rights, Dignity and Consultation

Some improvements were required to ensure choice was provided for all residents and practices did not become institutional in nature.

Residents spoken with told inspectors that they were offered choices in what time they get up and return to bed. They could choose what they wanted to eat and what activities they wished to participate in on a daily basis. However, inspectors noted that meal times varied for residents to facilitate staff rather than the residents. Some of the residents who preferred to remain in their bedrooms for meals received their evening meal at 3.30 pm and residents told inspectors that this was too early. This was discussed with the person in charge and the provider who stated that they would address this issue.

Inspectors noted that the privacy and dignity of residents was respected. Bedroom and bathroom doors were closed when personal care was being delivered. All bedrooms had a 'care in progress' sign on the door to indicate when care was being delivered. Staff were observed to knock and wait before entering bedrooms.

Residents were treated with respect. Inspectors heard staff addressing residents by their preferred names and speaking in a clear, respectful and courteous manner. Staff paid particular attention to residents' appearance and personal hygiene. Staff were observed to explain clearly what they were doing with the resident before actually carrying out the task so as to ensure the resident understood what was happening. Staff sought assurance from residents that they understood before proceeding. Staff were noted to use picture cards and a small wipe clean card to write and communicate with a resident who had communication difficulties. The resident was heard answering clearly to this form of communication.

A residents' committee was established and meetings were held every two months. The minutes of these meetings were posted on the residents' notice board so that those residents who could not attend were informed. Inspectors read the minutes of some of these meetings and noted that issues raised were discussed and acted upon. For example, residents who went to the dining room for their meals stated that they received their evening meal too early at 4.00 pm while other residents preferred their evening meal at that time. The person in charge and provider had arranged for two evening meal sittings, one at 4.00 pm and the second at 5.00 pm in the dining room to accommodate all residents. Residents spoken with confirmed this and were satisfied with this outcome. A Eucharistic Minister was available to act as the residents advocate if required.

Residents' religious and political rights were facilitated. The person in charge informed inspectors that most residents were Roman Catholic. Communion was given out daily and mass took place weekly and was relayed by audio link to residents' bedrooms. The person in charge advised inspectors that arrangements were in place for residents of different religious beliefs. The Church of Ireland minister visited and this was confirmed by residents. One resident was a Buddist and the elder visited him in the centre. The person in charge also told inspectors that residents were facilitated to vote and explained that residents had been facilitated to vote in-house during the recent national elections while one resident chose to go out to vote, residents confirmed this.

Inspectors noted that residents' autonomy and independence were promoted and residents were encouraged to remain active. Staff and the physiotherapist were observed encouraging and assisting residents to mobilise and walk to the dining room, day room, bathrooms and some residents were seen walking outside in the grounds.

Regulation 20: Food and Nutrition

Inspectors reviewed the comprehensive polices on monitoring residents nutritional intake and food and nutrition. Weight loss was closely monitored, nursing staff told the inspector that all residents were nutritionally assessed on admission and weights were recorded on a monthly basis. They said that if there was a change in a resident's weight, nursing staff would reassess the resident, inform the GP and referrals would be made to the dietician. Inspectors noted from the resident's files where some residents had been referred for dietetic review, recommendations from the dietician were recorded and incorporated in the residents' care plans. Nutritional supplements were prescribed by the GP as required. The chef informed inspectors that recommendations from the dietician were also copied to him in the kitchen. The nursing assessment undertaken on each resident identified their specific food likes/dislikes and preferences however while the chef did know the residents well this information was not available in the kitchen.

Inspectors noted some improvements could be made to enhance the dining experience for all residents. During the lunch time meal inspectors noted the noise level in the dining room to be very loud and some residents also commented on how disruptive the noise was for them. The noise came from serving the food from the bain maries in the kitchen and the scraping of dinner plates following the meal.

Inspectors were satisfied that residents received a nutritious and varied diet that offered choice. There was a large central dining room and some residents dined there while others who required assistance had their meal either in their bedroom or in the sitting rooms. The mealtime was a social occasion that provided opportunities for residents to interact with each other and staff. Staff and residents were observed chatting to one another over lunch and the atmosphere was relaxed and unhurried. Staff were observed encouraging residents to eat independently and offered assistance discreetly. Other staff were observed sitting beside residents who required assistance with eating.

Some residents required special diets or a modified consistency diet and these needs were met. The inspector noted that the quality, choice and presentation of the meals were of a high standard and both the inspectors who sampled the food and the residents spoken to confirmed this.

Inspectors saw residents being offered a variety of drinks throughout the day. Staff regularly offered drinks to residents and inspectors noted the fresh water available from dispensers. During lunch residents were offered wine with their meal.

Environment

Regulation 19: Premises

Inspectors noted that there was insufficient storage space for equipment. Hoists and other equipment were seen stored in residents' bathrooms during the day.

The environment was bright, clean and well maintained throughout and the building was observed to be appropriately heated, lighted and well ventilated.

Call bell facilities were available in all bedrooms and servicing records showed that regular servicing was undertaken. Inspectors noted that call bells were answered promptly and residents confirmed they were not left waiting for assistance.

There was appropriate assistive equipment available such as hoists, pressure relieving mattresses, cushions, specialized beds, chairs, wheelchairs and walking frames. Handrails and grab rails were provided to promote independence in the corridors and bathrooms. Hoists and all other equipment had been maintained and service records were up-to-date. A maintenance person was employed and was responsible for the day-to-day maintenance of the centre.

Regulation 32: Fire Precautions and Records

Adequate fire precautions were in place and records maintained.

The fire procedure on display gave clear guidance on what to do in the event of a fire. The fire policy was comprehensive and on review of the training records it was noted that all staff had received fire training. Staff were knowledgeable and able to tell inspectors what they would do in the event of a fire. Fourteen staff members had received fire marshal training and one staff member was designated as the fire marshal on a daily basis. This was communicated to all staff on the notice board in the staff rest room. Staff questioned on the day of inspection were able to tell inspectors who the designated fire marshal was for that day.

Service records showed that the fire alarm system was serviced quarterly, fire equipment on a yearly basis and emergency lighting three times a year. The inspector read the records which showed that daily inspections of fire exits were carried out along with a weekly inspection of fire doors and fire fighting equipment. The fire panels were in order and the inspector noted that fire exits were unobstructed. Weekly tests of the alarm system were undertaken every Wednesday.

Other Issues

Inspectors noted that the directory of residents did not include all of the information specified in Schedule 3 of the Regulations. The details of one resident's readmission to the centre following transfer from hospital were not recorded.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the provider, person in charge and support services manager to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

Acknowledgements

The inspectors wish to acknowledge the cooperation and assistance of the residents, relatives, provider and staff during the inspection.

Report compiled by:

Fiona Whyte

Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

5 August 2011

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report

Centre:	Cairn Hill Nursing Home
Centre ID:	0019
Date of inspection:	3 August 2011
Date of response:	30 August 2011

Requirements

These requirements set out what the registered provider must do to meet the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

1. The person in charge has failed to comply with a regulatory requirement in the following respect:

Inspectors were concerned that staffing levels at night might not be adequate to meet the needs and ensure the safety of the residents. Staffing levels reduced considerably to one nurse and two care assistants on duty at night time. Inspectors were also concerned that these staffing levels presented a risk to residents in the event of an emergency or if the building required to be evacuated during the night.

Staff files contained a self declaration of medical fitness for staff which was not in accordance with the requirements of the Regulations.

Action required:

Ensure that the numbers and skill-mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.

Action required: Put in place recruitment procedures to ensure that no staff members are employed in the designated centre unless they are physically and mentally fit for the purposes of the work which they are to perform.	
Reference: Health Act, 2007 Regulation 16: Staffing Regulation 18: Recruitment Standards 22: Recruitment Standard 23: Staffing Levels and Qualifications	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The nursing hours have been reconfigured to ensure there are sufficient staff to meet residents needs and to ensure the safety of residents at night. There was an identifed gap between 8.00 pm and 10.00 pm where there was one nurse on duty, who had responsibility for administering medication. The staff allocation has been revised and increased to ensure that there are two staff nurses on duty over this period, one to administer medications and one to respond to emergencies/manage care. Please see Appendix 1 for revised nursing rota. Staff have been informed of the need to obtain a medical certificate from a GP stating that they are fit to work. Cairn Hill has arranged for a GP to examine any staff without medical certificates and to provide reports on whether they are physically and mentally fit to work. These reports shall be returned to the Support Services Manager and filed on the staff member's staff file by 1 October 2011. The policy and procedure entitled 'Staff Recruitment, Selection and Appointment' has been updated to state that new staff members must provide a medical certificate from a GP certifying that they are mentally and physically fit for work before they commence employment. All members of the management team have signed to state that they have read and understood this policy and procedure. Please see Appendix 2 for revised policy and procedure and copy of sign-off sheet.	Completed 01/10/2011 Completed

2. The provider has failed to comply with a regulatory requirement in the following respect:

All levels were accessible by stairs and there were no risk assessments undertaken to ensure control measures were in place to minimise the risk of residents falling down the stairs.

All the stairs in the centre had a handrail on one side only which posed a safety risk to residents.

The emergency plan did not provide guidance on what to do in the event of emergencies such as power failure, loss of heating and disruption to water supply.

Sluicing of soiled laundry was regularly undertaken in the sluice room and then transported along the corridor in a basin to the laundry. This practice posed a risk of infection.

Cleaning detergents and chemicals were noted to be stored unsecured in the kitchen where food was being prepared.

Action required:

Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.

Action required:

Provide handrails on both sides of stair cases except where a stair lift is provided.

Action required:

Put in place an emergency plan for responding to emergencies.

Action required:

Put in place a comprehensive written risk management policy and implement this throughout the designated centre.

Reference:

Health Act, 2007
Regulation 31: Risk Management Procedures
Standard 26: Health and Safety
Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response:	
All residents undergo a falls risk assessment on admission (reviewed thereafter at three-monthly intervals or sooner if required) determined by use of the validated FRAT tool. In addition all residents who use the stairs have been assessed to determine their suitability to use the stairs, and any risks associated with using the stairs if they choose to. Details have been documented in their care plan. Staff are being continually reminded by the director of nursing to be observant of residents on the stairs during the day.	Completed
Handrails have been installed to ensure there are handrails on both sides of the staircases. Please see Appendix 3 for photographs of the newly installed handrails in the stairways.	Completed
Use of the risk management policy and register have been reviewed. All members of the management team have attended risk management training. The Cairn Hill risk policy and register have been reviewed and updated. The register was on the agenda for the care staff meeting on 25 August 2011 and will be on the agenda for all future management team meetings to ensure it is continually reviewed and updated as required. Please see Appendix 4 for details of education and training provided, Appendix 5 for training certificates, Appendix 6 for care staff team agenda on 25 August and management team agenda scheduled for 30 August 2011.	Completed
The emergency plan has been reviewed to incorporate all relevant emergencies. See Appendix 7 for revised emergency plan.	Completed
Alginate bags for moving soiled laundry have been purchased and staff have been briefed on the use of same. Support Services Manager is monitoring staff to ensure they are used.	Completed
The cleaning detergents and chemicals have been moved to a designated shelf in a locked cupboard.	Completed

3. The provide has failed to comply with a regulatory requirement in the following respect:

The complaints policy and procedure required some improvements. The complaints policy did not identify to whom a person could make a complaint to and it did not contain details of an independent appeals process. The complaints procedure on display was a flow chart and was very difficult to read. It also did not state clearly who a person could complain to and the independent appeals process.

Action required:

Provide written operational policies and procedures relating to the making, handling and investigation of complaints from any person about any aspects of service, care and treatment provided in, or on behalf of a designated centre.

Action required:

Ensure the complaints procedure contains an independent appeals process, the operation of which is included in the designated centre's policies and procedures.

Action required:

Make available a nominated person in the designated centre to deal with all complaints.

Reference:

Health Act, 2007
Regulation 39: Complaints Procedures
Standard 6: Complaints

Please state the actions you have taken or are planning to take following the inspection with timescales:	**Timescale:**
Provider's response:	
The director of nursing is the nominated person in Cairn Hill Nursing Home to deal with all complaints.	Completed
The flowchart displayed to residents and visitors has been updated to ensure it is clear to read, and the person responsible for dealing with complaints is readily identified.	Completed
The policy and procedure for complaints management has been updated to include reference to the independent appeals process. Where a complainant requires an independent review of a complaint, a team consisting of three resident relatives/family members/next-of-kin, independent to the complainant, shall be established and shall review the complaint.	Completed
Please see Appendix 8 for the revised flow chart and complaints policy and procedure.	Completed

4. The person in charge has failed to comply with a regulatory requirement in the following respect:

Inspectors noted that the incidence of pressure ulcers grade two or higher were not notified to the Chief Inspector as required.

Action required: Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any serious injury to a resident.	
Reference: Health Act, 2007 Regulation 36: Notification of Incidents Standard 29: Management Systems Standard 30: Quality Assurance and Continuous Improvement Standard 32: Register and Residents' Records	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Details of the pressure ulcer were notified to the Chief Inspector. The director of nursing shall ensure all serious injury to the resident is notified to the Chief Inspector without delay.	Completed

5. The person in charge has failed to comply with a regulatory requirement in the following respect: Improvement was also required to ensure the more dependent and cognitively impaired residents received meaningful interaction and stimulation. Activities were limited for those residents who were more dependent and cognitively impaired than for residents' who were more independent and able to participate.	
Action required: Provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities.	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 13: Healthcare Standard 18: Routines and Expectations	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response: Cairn Hill Nursing Home is committed to developing the activities programme for residents who are more dependent and cognitively impaired. To achieve this, our nominated activities coordinator successfully completed a course in May 2011 on 'Developing an Activities Programme for Older People in Day and Residential Settings'. Please see certificate of successful completion at Appendix 9. Since the recent inspection, the activities coordinator has completed additional training, attending a one-day workshop entitled 'Workshop Exploring Activity Programming within the Care Home Setting', completed on 20 August 2011. Please see Appendix 10 attached for certificate of attendance and course itinerary. The activities coordinator is scheduled to undertake further training with a five-day training course on 'Best Practice in Dementia Care'. The course is scheduled for 24 – 28 October 2011. Please see Appendix 11 for confirmation of payment and booking and course itinerary. Following the courses, the activities coordinator shall review and develop the activities schedule for all residents who are more dependent and cognitively impaired. This shall be reviewed and approved with input from the director of nursing. The director of nursing, activities coordinator and nominated staff nurse shall meet monthly to review the activities schedule specifically for residents who are more dependent and cognitively impaired. In-house education and training has been scheduled for healthcare assistants entitled 'Person-centred Approach to Dementia Care'. Training will be completed by end of October 2011. The course is an intensive one day course. Please see Appendix 12 for course outline.	Completed Completed 24/10/2011 – 28/10/2011 Commenced and ongoing October 2011

6. The provider has failed to comply with a regulatory requirement in the following respect:

Some improvements were required to ensure choice was provided for all residents and practices did not become institutional in nature. Some residents received their evening meal at 3.30 pm and they felt that this was too early.

Action required:

Provide each resident with the freedom to exercise choice to the extent that such freedom does not infringe on the rights of other residents.

Reference: Health Act, 2007 Regulation 10: Residents' Rights, Dignity and Consultation Standard 17: Autonomy and Independence Standard 18: Routines and Expectations	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The evening meal is predominantly served at 4.00 pm as per resident choice. A number of residents have their meal later at 5.00 pm as per their individual choice and care plan. Management have clarified with staff that meals are not to be served any earlier than 4.00 pm. A review of resident choices and preferences regarding mealtimes was conducted in July 2011 and discussed at the management team meeting. It was following this meeting with residents that the 5.00 pm mealtime was introduced. A follow-up review is scheduled for September to continue to ensure that residents have choice regarding mealtimes.	Completed 30/09/2011

8. The provider has failed to comply with a regulatory requirement in the following respect: There was insufficient storage space for equipment. Hoists and other equipment were seen stored in residents' bathrooms during the day.	
Action required: Provide suitable storage facilities.	
Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's Response: The registered provider is reviewing the layout of the nursing home to identify additional storage facilities for the hoists and any other equipment which did not previously have an identified storage space. Structures shall be built where required to provide storage for the equipment.	31/10/2011

9. The person in charge has failed to comply with a regulatory requirement in the following respect: The directory of residents did not contain the details of the residents' readmission to the centre following transfer from hospital.	
Action required: Ensure that the directory of residents includes the information specified in Schedule 3 of the Regulations.	
Reference: Health Act, 2007 Regulation 23: Directory of Residents Standard 32: Register and Residents' Records	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The omission from the register was identified and reviewed. The process for ensuring the register is up-to-date has been reviewed. On a monthly basis the director of nursing shall audit the directory of residents to ensure it is comprehensive and provide the results of the audit to the management team.	 Completed Commenced and ongoing

Recommendations

These recommendations are taken from the best practice described in the *National Quality Standards for Residential Care Settings for Older People in Ireland* and the registered provider should consider them as a way of improving the service.

Standard	Best practice recommendations	Timescale
Standard 19: Meals and Mealtimes	Inspectors noted some improvements could be made to enhance the dining experience for all residents. The noise level in the dining room was noted to be very loud and disruptive for residents. The nursing assessment undertaken on each resident identified their specific food likes/dislikes and preferences however this information was not available in the kitchen.	
	Provider's response: Information and education has been provided to the kitchen and healthcare staff about the level of noise in the dining room. It was noted that a large volume of the noise generated was due to plates being cleared and scraped. To address this, Cairn Hill has introduced plastic spatulas to clear plates instead of metal cutlery previously used and this has greatly reduced the volume of noise generated. The director of nursing and clinical nurse manager shall increase supervision of the dining room to promote a calm and relaxed environment. The director of nursing and chef has compiled a list of resident likes/dislikes that is reflective of the information stored in the resident record, and is located in the kitchen. This shall be reviewed when new residents are admitted to Cairn Hill Nursing Home.	Commenced and ongoing Commenced and ongoing

Any comments the provider may wish to make:

Provider's response:

We would like to take this opportunity to thank the inspectors for their feedback on the day of the inspection, and in this report. We are committed to providing the highest quality of care for our residents and to use the feedback from the inspection process as a mechanism for continuing to improve our care and service.

Provider's name: BRD Nursing Home Ltd
Date: 30 August 2011